HOCKEY CANADA INJURY REPORT

See reverse for mailing address

Forms must be filled out in full or form will be returned. *This form must be completed for each case where an injury is sustained by a player, spectator or any other person at a sanctioned hockey activity*

CLAIMS MUST BE PRESENTED WITHIN 90 DAYS OF THE INJURY DATE: ____/____/____ Mo. Day Yr.

INJURED PARTICIPANT: ☐ Player ☐ Team Official ☐ Game Official ☐ Spectator

Name: _____ Birthdate: ____/____/____ Mo. Day Yr. Sex: (M) (F)

Address: _____ City / Town: _____

Province: _____ Postal Code: _____ Phone: (_____)_____

Parent / Guardian:

DIVISION:
☐ Initiation ☐ Novice ☐ Atom ☐ PeeWee
☐ Bantam ☐ Midget ☐ Juvenile

CATEGORY:
☐ AAA ☐ AA ☐ A ☐ B ☐ BB ☐ C ☐ CC
☐ D ☐ DD ☐ E ☐ House ☐ Major Junior ☐ Minor Junior
☐ Senior ☐ Adult Rec ☐ Other _____

BODY PART INJURED: * visit the Hockey Canada web-site for an optional questionnaire *

Head		**Back**	**Trunk**	**Arm** ☐ **Left** ☐ **Right**		**Pelvis**	**Leg** ☐ **Left** ☐ **Right**	
☐ Eye Area	☐ Face	☐ Neck	☐ Ribs	☐ Shoulder	☐ Hand/Finger	☐ Hip	☐ Thigh	☐ Foot
☐ Throat	☐ Dental	☐ Upper	☐ Chest	☐ Upperarm	☐ Forearm/Wrist	☐ Groin	☐ Knee	☐ Toe
☐ Skull		☐ Lower	☐ Abdomen	☐ Elbow	☐ Collarbone		☐ Shin	☐ Other

NATURE OF CONDITION:
☐ Concussion ☐ Laceration ☐ Fracture ☐ Sprain ☐ Strain
☐ Contusion ☐ Dislocation ☐ Separation ☐ Internal Organ Injury

ON-SITE CARE: ☐ On-Site Care Only ☐ Refused Care
☐ Sent to Hospital by: ☐ Ambulance ☐ Car

INJURY CONDITIONS: **Name of arena / location:** _____
☐ **Exhibition / Regular Season** ☐ **Playoffs / Tournament** ☐ **Practice** ☐ **Try-outs** ☐ **Other**
☐ Warm-up ☐ Period #1 ☐ Period #2 ☐ Period #3 ☐ Overtime # _____
☐ Dry Land Training ☐ Gradual Onset ☐ Other Sport ☐ Other: _____

Was the injured player in the correct league and level for their age group? ☐ **Yes** ☐ **No**
Was this a sanctioned Hockey Canada activity? ☐ **Yes** ☐ **No**

CAUSE OF INJURY:
☐ Hit by Puck ☐ Collision with Boards ☐ Non-Contact Injury
☐ Hit by Stick ☐ Collision on Open Ice ☐ Collision with Opponent
☐ Fall on Ice ☐ Checked From Behind ☐ Collision with Net
☐ Fight ☐ Blindsiding

LOCATION:
☐ Defensive Zone ☐ Offensive Zone ☐ Neutral Zone
☐ Behind the Net ☐ 3 ft. from Boards ☐ Spectator Area
☐ Parking Lot ☐ Dressing Room ☐ Bench
☐ Other: _____

WEARING WHEN INJURED:
☐ Full Face Mask ☐ Intra-Oral Mouth Guard
☐ Half Face Shield/Visor ☐ Throat Protector
☐ Helmet/No Face Shield ☐ No Helmet/No Face Shield
☐ Short Gloves ☐ Long Gloves

ADDITIONAL INFORMATION:
Has the player sustained this injury before? ☐ Yes ☐ No
If "Yes" how long ago _____
Was a penalty called as a result of the incident? ☐ Yes ☐ No
Estimated Absence from hockey? ☐ 1 week ☐ 1-3 weeks ☐ 3+ weeks

DESCRIBE HOW ACCIDENT HAPPENED: (Attach page if necessary)

I hereby authorize any Health Care Facility, Physician, Dentist or other person who has attended or examined me/my child, to furnish Hockey Canada any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment and copies of all dental, hospital, and medical records. A photostatic/electronic copy of this authorization shall be considered as effective and valid as the original.

Signed: _____ Date: _____
(Parent/Guardian if under 18 years of age)

TEAM INFORMATION: (To be completed by a Team Official)

Association: _____ Team Name: _____

Team Official (Print) _____ Team Official Position: _____

Signature: _____ Date: _____

HEALTH INSURANCE INFORMATION:
THIS MUST BE FILLED OUT IN FULL OR FORM PROCESSING WILL BE DELAYED

Occupation: ☐ Employed Full-time ☐ Employed Part-time ☐ Unemployed ☐ Full-Time Student
Employer (If minor, list parent's employer): _____

1. Do you have provincial health coverage? ☐ Yes ☐ No Province: _____
2. Do you have other insurance? ☐ Yes ☐ No (IF "YES", PLEASE SUBMIT CLAIM TO YOUR PRIMARY HEALTH INSURER.)
3. Has a claim been submitted? ☐ Yes ☐ No (IF "YES", PLEASE FORWARD PRIMARY INSURER EXPLANATIONS OF BENEFITS.)

Make Claim Payable To: ☐ Injured Person ☐ Parent ☐ Team ☐ Other: _____

Branch APPROVAL

PHYSICIAN'S STATEMENT

Physician: _____ Address: _____ Tel: (____)_____

Name of Hospital / Clinic: _____ Address: _____

Nature of Injury: _____ Date of First Attendance: _____

_____ Claimant will be totally disabled:

_____ From: _____ To: _____

Is the injury permanent and irrecoverable? ☐ No ☐ Yes

Give the details of injury (degree): _____

_____

Prognosis for recovery: _____

_____

Did any disease or previous injury contribute to the current injury? ☐ No ☐ Yes (describe): _____

_____

Was the claimant hospitalized? ☐ No ☐ Yes (give hospital name, address and date admitted):

_____

_____

Names and addresses of other physicians or surgeons, if any, who attended claimant: _____

_____

I certify that the above information is correct and the best of my knowledge,

Signed: _____ Date: _____

DENTIST STATEMENT

Limits of coverage: $1,000 per tooth, $2,000 per accident
Treatment must be completed within 52 weeks of accident

	UNIQUE NO. SPEC. PATIENT'S OFFICIAL ACCOUNT NO.	I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM DIRECTLY TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM / HER
PATIENT LAST NAME GIVEN NAME _____ ADDRESS APT. _____ CITY PROV. POSTAL CODE	DENTIST PHONE NO.	_____ SIGNATURE OF SUBSCRIBER

FOR DENTIST USE ONLY – FOR ADDITIONAL INFORMATION, DIANOGNIS OR SPECIAL CONSIDERATION.

DUPLICATE FORM ☐

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY PLAN BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE TREATMENT.
I ACKNOWLEGDE THAT THE TOTAL FEE OF $ _____ IS ACCURATE AND HAS BEEN CHARGED TO ME FOR THE SERVICES RENDERED.
I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY/PLAN ADMINISTRATOR.

_____
SIGNATURE OF (PATIENT/GUARDIAN)

_____
OFFICE VERIFICATION

DATE OF SERVICE DAY / MO. / YR.	PROCEDURE	INITIAL TOOTH CHARGE	TOOTH SURFACE	DENTIST'S FEE	LAB CHARGE	TOTAL CHARGE

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE & OE.

TOTAL FEE SUBMITTED

NOTE: All benefits subject to insurer payor status, provisions of the policy, Hockey Canada sanctioned events.

Mail completed form to:
ALLIANCE Hockey
71 Albert Street Stratford, ON N5A 3K2
Tel : 519-273-7209 Fax : 519-273-2114